STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR RIDGE	2700 WATERS EDGE PARKWAY JEFFERSONVILLE, IN47130

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: September 19, 20, and 21, 2011 Facility number: 004001 Provider number: 004001 AIM number: N/A Survey team: Gloria J. Reisert, MSW/TC Dorothy Navetta, RN (9/19 and 9/20/2011) Census Bed Type: Residential: 37 Total 37 Census Payor Type: Other: 37 Total 37 Residential Sample: 07 Supplemental Sample: 04 These State Residential Findings are cited in accordance with 410 IAC 16.2 Quality review completed on September 23, 2011 by Bev Faulkner, RN	R0000	F000 Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R0121	(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the	R0121	R121 Personnel The facility will	09/23/2011

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	facility failed to ensure tuberculin skin testing was performed and the results were recorded prior to the employees starting work for 4 of 10 employees whose files were reviewed. (LPN #1 and #2, CNA [Certified Nursing Assistant] #1, Laundry Aide #1) Findings include: During a review of the employee files on 9/20/2011 at 3:00 p.m., the following was noted: 1. LPN #1 was hired on 7/5/2011 into the nursing department and began working with residents on 7/6/2011. Review of her file indicated she had received her first-step PPD [tuberculin skin test] on 7/4/2011, which was read on 7/7/2011 - 1 day after she had begun working with residents. 2. Laundry Aide #1 was hired into the Housekeeping Department on 6/29/2011 and began working with the residents on the same day. Review of her file indicated she had received her first-step PPD on 6/30/2011 which was read on 7/3/2011 - 4 days after she began working with residents. 3. LPN #2 was hired on 7/11/2011 into the nursing department and began working		ensure this requirement is met through the following corrective measures:1. First and second step PPD's have been completed on employees LPN #1, LPN #2, CNA #1, and Laundry Aide #1. No positive reactions were noted. 2. All active employee files have been audited to ensure the two-step method was utilized, when indicated.3. Administrative nursing staff have been re-educated on the infection control policy related to Employee Tuberculosis Screening (see attachment A). The administrative designee will review all newly hired employee files to ensure tuberculosis screening has been completed as outlined in the policy prior to starting orientation for 4 weeks and again within 21 days of starting, ensuring any required 2nd step PPD's are completed timely. After 4 weeks, he/she will audit 10 employee files per month for 2 months, then 10 per quarter to ensure continued compliance (see attachment B).4. The results of ongoing audits shall be reported to the administrator on a monthly basis as means of quality assurance. The plan of action will be adjusted accordingly.5. The above corrective measures will be completed on or before September 23, 2011.	

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	with the residents on the same day. Review of her file indicated she had received her first-step PPD on 7/11/2011, which was read on 7/14/2011 - 3 days after she had begun working with the residents. 4. CNA #1 was hired on 8/22/2011 into the nursing department and began working with the residents on 8/23/2011. Review of her file indicated she had received her first-step PPD on 8/23/2011, which was read on 8/26/2011 - 3 days after she had begun working with the residents. On 9/20/2011 at 4:45 p.m., the Director of Nursing [DoN] presented a copy of the facility's current policy on "Employee Health/Communicable Disease". Review of this policy at this time included, but was not limited to: "Policy: The facility shall prohibit employees with communicable disease or infected skin lesions from direct contact with residents or their food. Procedure: 1.) SCREENING: a. All employees will undergo tuberculosis screening when hired by this facility..." The Administrator and the DoN indicated at this time that after checking the employee files, the named staff members should not have had contact with the			

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	residents until their first-step PPDs had been read.			
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure the Level of Service/Evaluations were reviewed and/or revised semiannually or as changes occurred for 5 of 7 residents reviewed for Level of Service/Evaluations in a sample of 7 residential residents (Residential Resident #1, 41, 3, 5 and 40) Findings include: 1. Review of the clinical record for Resident # 1 on 9/19/2011 at 12:30 p.m., indicated diagnoses included, but were not limited to, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes mellitus type 2, and renal failure. Resident # 1 was admitted on 7/12/2010 and a "Level of Service Assessment/Evaluation" was completed.	R0214	R 214 Evaluation The facility will ensure this requirement is met through the following corrective measures:1. A Level of Service Assessment/Evaluation has been completed for residents #1, #3 and #5. Residents #40 and #41 have been discharged.2. All residents have the potential to be affected. Level of Service Assessments/Evaluations were reviewed on all residents to ensure each resident's self-care abilities and needs have been identified.3. Licensed nursing staff were re-educated on the need to complete a new Level of Service Assessment/Evaluation upon admission, when a change in condition is noted, and at least semi-annually thereafter (see policy- attachment C). As means of Quality assurance, the administrative designee shall audit the record of each newly admitted or re-admitted resident within 72 hours of admission and	09/23/2011

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	On 7/15/2011, another Level of Service/Evaluation had been completed. Documentation was lacking of a semi-annual assessment having been completed in January 2011. 2. On 9/19/2011 at 1:45 p.m., the closed record review of Resident # 41 included diagnoses; but were not limited to, chronic renal failure, hypertension (high blood pressure), and gout. The resident was admitted to residential on 7/22/2009 and was discharged to the hospital on 7/1/2011 The last "Level of Service Assessment/Evaluation" was completed on 4/5/2010. Documentation was lacking of any further Level of Service Assessments having been completed since that date. 3. Review of the clinical record for Resident #3 on 9/19/2011 at 1:20 p.m., indicated the resident was admitted to the facility on 9/3/2010 and had diagnoses which included, but were not limited to: Parkinson's, osteoporosis, hypertension, degenerative disk disease, and anemia. On 9/3/2010, the initial Level of Service Assessment/Evaluation had been completed. A subsequent Level of Service/Evaluation had been completed		review the 24 hour report forms daily, on scheduled work days, to verify the completion of or need to re-complete an evaluation of the individual needs of the resident (see attachment D).4. The results of ongoing audits shall be reported to the administrator on a monthly basis as means of quality assurance and the plan of action adjusted accordingly. 5. The above correction measures will be completed on or before September 23, 2011.	

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	on 8/17/2011. Documentation was lacking of any further semi-annual evaluations having been completed between 9/3/2010 and 8/17/2011. 4. Review of the clinical record for Resident #5 on 9/19/2011 at 12:25 p.m., indicated the resident was initially admitted to the facility on 12/1/2008 and again re-admitted on 9/1/2011 after sustaining a compression fracture to her lumbar spine. On 9/16/2010, a Level of Service Assessment/Evaluation had been completed with a subsequent one being completed on 8/5/2011. Documentation was lacking of any Level of Service Assessments/Evaluations having been completed semi-annually between 9/16/2010 and 8/5/2011. On 9/1/2011, the resident returned from a 2 day stay in the hospital due to a compression fracture of her lumbar spine. Review of the nursing notes between 9/1/2011 and 9/15/2011 and the 9/2/2011 Nursing Summary, indicated the resident had a decline in her overall status. Among the changes were, the resident now had a back brace, required 1 assist with her Activities of daily Living, was getting Physical Therapy, and had increased			

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	weakness. Documentation was lacking of a new Level of Service Assessment/Evaluation having been completed. During an interview with the Director of Nursing on 9/20/2011 at 4:45 p.m., she indicated a new assessment probably should have been completed to reflect her current status. 5. Review of the closed clinical record for Resident #40 on 9/19/2011 at 2:25 p.m., indicated the resident had initially been admitted to the facility on 7/24/2009 with subsequent re-admissions from the area psychiatric hospitals on 7/7/2011 and 7/29/2011. On 9/15/2010, a Level of Service Assessment/Evaluation had been completed. Documentation was lacking of any further semi-annual Level of Service Assessments/Evaluations having been completed. On 7/7/2011, the resident had signed herself out of the psychiatric hospital after only 2 days and returned to the facility. On 7/29/2011, the resident again returned to the facility after a 14 days stay in the psychiatric hospital. Both stays were due to severe behavioral issues. Documentation was lacking of a new			

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	Level of Service Assessment/Evaluation having been completed after both stays to reflect the current status of the resident and level of assistance needed and behavioral issues. During an interview with the DoN on 9/20/2011 at 4:45 p.m., she indicated she was unable to locate any other Level of Service Assessments/Evaluations completed and could not explain why there were gaps in between assessments on Residents #1, 41, 3, 5, and 40. On 9/19/2011 at 10:00 a.m., the Administrator presented a copy of the facility's current policy on "Evaluation of Individual Resident Needs". Review of the policy at this time included, was not limited to: "Policy: It is the policy of this facility that the individual needs of each resident will be assessed prior to and upon admission/readmission to the facility. Said assessments will be updated quarterly. More frequent assessments will be performed upon the resident's request or at the time of a known substantial change in the resident's condition. Assessments will address the resident's physical/mental status, independence with activities of daily living..."			

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to review/revise the Service plans on a semi-annual basis or as changes occurred for 2 of 7 residential residents reviewed for Service plans in a	R0217	R 217- Evaluation The facility will ensure this requirement is met through the following corrective measures:1. The Service plan for resident #5 has been reviewed and revised as indicated. 2. All residents have the potential to be	09/23/2011

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	sample of 7 residential residents. (Residential residents #5 and 40) Findings include: 1. Review of the clinical record for Resident #5 on 9/19/2011 at 12:25 p.m., indicated the resident was initially admitted to the facility on 12/1/2008 and again re-admitted on 9/1/2011 after sustaining a compression fracture to her lumbar spine. On 9/16/2010, a Service plan had been completed with a subsequent one being completed on 8/11/2011. Documentation was lacking of any Service plans having been completed semi-annually between 9/16/2010 and 8/11/2011. On 9/1/2011, the resident returned from a 2 day stay in the hospital due to a compression fracture of her lumbar spine. Review of the nursing notes between 9/1/2011 and 9/15/2011 and the 9/2/2011 Nursing Summary, indicated the resident had a decline in her overall status. Among the changes were, the resident now had a back brace, required 1 assist with her Activities of daily Living, was getting Physical Therapy, and had increased weakness. Documentation was lacking of a new Service Plan having been		affected and all service plans were audited for compliance. (See attachment D).3. In an effort to ensure ongoing compliance, administrative staff have been re-educated on indications of when to complete a new level of care assessment and subsequent service plan (see also attachment C). As means of quality assurance, the administrative designee shall audit the record of each newly admitted/re-admitted resident with 72 hours of admission/re-admission and the 24-hour report sheets daily, on scheduled work days, to ensure the service plan is revised to accurately reflect resident performance and provision of care by staff indefinitely (see attachment D).4. The results of ongoing audits shall be reported to the administrator on a monthly basis as a means of quality assurance and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before September 23, 2011.	

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	completed. During an interview with the Director of Nursing on 9/20/2011 at 4:45 p.m., she indicated a new assessment and plan of care probably should have been completed to reflect her current status. 2. Review of the closed clinical record for Resident #40 on 9/19/2011 at 2:25 p.m., indicated the resident had initially been admitted to the facility on 7/24/2009 with subsequent re-admissions from the area psychiatric hospitals on 7/7/2011 and 7/29/2011. On 1/10/2010, a Service plan had been completed. Documentation was lacking of any further Service plans having been completed. On 7/7/2011, the resident had signed herself out of the psychiatric hospital after only 2 days and returned to the facility. On 7/29/2011, the resident again returned to the facility after a 14 days stay in the psychiatric hospital. Both stays were due to severe behavioral issues. Documentation was lacking of a new Service plan having been completed after both stays to reflect the current status of the resident and level of assistance needed and behavioral issues.			

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	During an interview with the DoN on 9/20/2011 at 4:45 p.m., she indicated she was unable to locate any other Service plans completed and could not explain why there were gaps in between Service plan reviews for Residents # 5, and 40. On 9/19/2011 at 10:00 a.m., the Administrator presented a copy of the facility's current policy on "Evaluation of Individual Resident Needs". Review of this policy at this time included, but was not limited to: "Policy:...Upon completion of an evaluation/assessment, the facility, using the appropriately trained staff, shall identify and document the services provided to the resident by the facility, in the form of a service plan, as follows: Procedure: 1. The services offered to the individual resident shall be appropriate to the scope, frequency, need and preference of the resident/ 2. The services offered shall be reviewed and revised as appropriate, and discussed by the resident and the facility as needs/desires change..."			

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R0356	(i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the emergency file contained all information required (hospital preference and correct apartment number) for 2 of 7 residents' (Residents 1 and 4) and 2 of 4 supplemental residents' (Residents 8 and 9) whose Emergency Files were reviewed in a sample of 7 residential residents and 4 supplemental residential residents [R - Resident] Findings included: Review of the emergency file book for all of the residents currently residing in the facility on 9/19/2011 at 1:55 p.m., noted the following information missing:	R0356	R356-Clinical Records The facility will ensure this requirement is met through the following corrective measures: 1. Residents #1, #4, #8, and #9's emergency records have been corrected and reflect the current hospital preference and location of the residents.2. All emergency files were audited to ensure necessary information is provided.3. Administrative staff have been re-educated on the emergency record-keeping (see attachment E).4. As a means of quality assurance, the Administrator shall be responsible to assess completion of the emergency file of each newly admitted resident to confirm continued compliance (see attachment F). Should	09/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR RIDGE	2700 WATERS EDGE PARKWAY JEFFERSONVILLE, IN47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Resident #1 was admitted to the facility on 7/12/2010. Review of the Admission face sheet noted the resident was listed as being in Apartment #124 instead of her current apartment - #120. 2. Resident #4 was admitted to the facility on 8/7/2011. Review of the Admission face sheet noted the resident was listed as being in Apartment #134 instead of his current apartment - #132. 3. Resident #8 was admitted to the facility on 1/27/2011. Review of his Admission face sheet had a note which indicated the resident was not to be transferred to the hospital unless trauma occurred. Documentation of a hospital preference in case of an emergency was lacking. 4. Resident #9 was admitted to the facility on 10/29/2009. Review of the Admission face sheet noted the resident as being in Apartment #103 instead of her current apartment - #135. During an interview with the Administrator and the Corporate RN on 9/20/2011 at 10:30 a.m., they indicated they had done a complete audit of the resident face sheets and corrected all records that contained the wrong information to reflect the current status of		non-compliance be noted, re-education and disciplinary action shall be taken as warranted.5. The above corrective measures will be completed on or before September 23, 2011.	

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	the residents.			